TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Michael Castro D.C.

**Respondent Name**
Accident Fund General Insurance

**MFDR Tracking Number**
M4-17-3306-01

**Carrier's Austin Representative**
Box Number 06

**MFDR Date Received**
July 13, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The approval letter provided by the insurance carrier does not support that the approval included a discussion to limit the number of units being authorized."

**Amount in Dispute:** $923.67

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Carrier properly calculated reimbursement in this case and stands by the reasons for reduction or denial of payment set forth in its Explanation of Benefits previously filed in this dispute."

**Response Submitted by:** Stone Loughlin Swanson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 27, 2017 through June 13, 2017 | 97140 | $923.67 | $261.34 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached

- 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is Medicare payment policy?
3. What rule is applicable to reimbursement guidelines?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The health care provider is seeking reimbursement of $923.67 for physical therapy services performed from April 27, 2017 through June 13, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   28 Texas Administrative Code 134.600 (c) (1) (B) and (p) (5) (A) states in pertinent parts,

   The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

   (i) Modalities, both supervised and constant attendance;

   Review if document dated April 24, 2017 the found;

   NOTIFICATION OF CERTIFICATION:

| Requested Service Description | Certified Quantity | Start Date | End Date |
|---|---|---|---|
| Physical Therapy 3xWk x 4 Wks Left Shoulder 97110 97530 97140 | 12 Physical Therapy | 04/24/2017 | 06/02/17 |

   Based on the evidence submitted with this dispute, the Division finds for the time period April 24, 2017 through June 2, 2017 no limits were placed on the units associated with approved services. Therefore, the carrier's denial is not supported for these dates of service.

   For dates of service June 5, 2017, June 6, 2017, June 8, 2017, June 12, 2017 and June 13, 2017, insufficient evidence was found to support the services were prior authorized without limits. Therefore, the carrier's denial is supported for these dates of service.

   The services in dispute from April 24, 2017 through June 2, 2017 will be reviewed per applicable fee guidelines.

2. 28 Texas Administrative Code 134.203 (a) (5) and (b) (1) states in pertinent part,

"Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, states in applicable section 10.7,

*Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.*

*Full payment is made for the unit or procedure with the highest PE payment.*

*For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day,* ***full payment is made for work and malpractice and 50 percent payment is made for the PE for services*** *submitted on either professional or institutional claims.*

Review of the Physician fee schedule at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx finds;

| Submitted Code | Physician Fee Schedule Allowable | Practice Expense | Work Expense (Full payment) | Malpractice Expense (Full payment) | 50 per cent of PE | Total |
|---|---|---|---|---|---|---|
| 97140 | 30.83 | 0.41 | 0.43 x $30.83 = $13.26 | 0.01 x $30.83 = $.31 | 0.41 X 30.83 = $12.64 x 50% = $6.32 | $13.26 + 0.31 +6.32 = $19.89 |

The calculation of the maximum allowable reimbursement is shown in the next paragraph.

3. 28 Texas Administrative Code 134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

| Date of Service | Submitted Code | Ranking | Units | DWC Conversion Factor/Medicare Conversion Factor x Allowable = MAR |
|---|---|---|---|---|
| April 27, 2017 | 97140 | Second | 1 | 57.5/35.8887 x $19.89 = $31.87 |
| May 4, 2017 | 97140 | First | 1 | 57.5/35.8887 x $30.83 = $49.40 |
| May 11, 2017 | 97140 | First | 1 | 57.5/35.8887 x $30.83 = $49.40 |
| May 18, 2017 | 97140 | First | 1 | 57.5/35.8887 x $30.83 = $49.40 |
| May 25, 2107 | 97140 | Second | 1 | 57.5/35.8887 x $19.89 = $31.87 |
| June 1, 2017 | 97140 | First | 1 | 57.5/35.8887 x $30.83 = $49.40 |
| | | | Total | $261.34 |

4. The total allowable reimbursement for the service in dispute is $261.34. This amount is due to the requestor.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $261.34.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $261.34, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 4, 2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.